

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04902

CERTIFICATE OF DEATH

94a
Reg. Dist. No. 95

1. PLACE OF DEATH:

County CecilCity or town Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Berg Bechtel

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

married

6. (b) Name of husband or wife

Rhoda Bechtel6. (c) If alive, give age 67 years

7. Birth date of deceased (mo. day, yr.)

Dec. 29. 1878

8. AGE:

Years	Months	Days	It less than one day
69	4	15	hrs. min.

9. Birthplace

Colona Cecil Co. Md.

(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

George K. Bechtel

FATHER

New Jersey

MOTHER

Mary B. Bechtel

MOTHER

Pottstown Pa.

16. Informant

Mrs. Rhoda Bechtel

Address

Rising Sun Md.

Burial

May. 18. 1948

(Month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

West Nottingham

Location

near Colona

18. Funeral director

J. E. Lyon

Address

Rising Sun Md.

May 16

19

(Date record registered)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

CecilCity or town Rising Sun Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 14

19 48 at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw h..... alive on

Immediate cause of death

Exsanguination

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

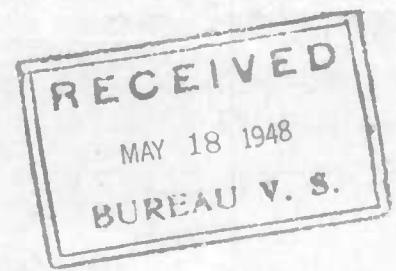
Re Dockson M.D.

Medical Examiner

Cecil County

M. D. or other

Address Rising Sun Md. Date signed May 15 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Underline correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04903

CERTIFICATE OF DEATH

94a
95
Reg. Dist. No.

1. PLACE OF DEATH

County

City or town

Port Deposit Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

Aug. 16. 1882 years

8. AGE: Years Months Days If less than one day

65 9 22 hrs. min.

9. Birthplace

(Town, county, and state)

Port Deposit Md.

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Arthur Bryde

13. Birthplace

New Orleans, Miss

14. Maiden name

addie Todd

15. Birthplace

Baltimore Md.

16. Informant

Donald Bruckley

Address

Rising Sun Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

West Nottingham

Location

Mar Cola

18. Funeral director

J. E. Jason

Address

Rising Sun Md.

19. Name (Date of death)

May 14. 1948

(Date fed by registrar)

5-14-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 7 1948 at 9

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., 10....., 19.....

and that I last saw h. alive on

19.....

Immediate cause of death

coronary
disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

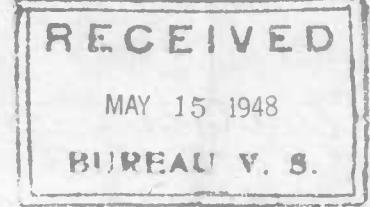
Medical Examiner
Cecil County

M. D. or other

Address Date signed

Plato daouche
Young Sun had 07/13/48

Young Sun had 07/13/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

04984

CERTIFICATE OF DEATH

Reg. Dlat. No. 92

1. PLACE OF DEATH:

County..... CecilCity or town..... Elk Mills

(If outside city or town limits, write RURAL and give nearest town)

35 years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary A.Charshee

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Wilmer Charshee6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 28, 18588. AGE: Years 90 Months 1 Days 7 If less than one day hre. min.9. Birthplace Hayre de Grace, Harford Co., Md.
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Thomas A. Glover13. Birthplace Baltimore, Maryland14. Maiden name Margaret J. Wright15. Birthplace Dorchester Co., Maryland16. Informant Essie R. WattsAddress Elk Mills, Maryland17. Burial Date thereof May 8th, 1948
(Burial, cremation, or removal. Which?)Cemetery or crematory Angel HillLocation Hayre de Grace, Maryland18. Funeral director Joseph A. GrantAddress North East, Maryland19. May 7, 1948 (Date rec'd by registrar)F. R. Traeger
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Elk Mills (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 May 1948 at 2:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947 to 5 May 1948 and that I last saw her alive on 4 May 1948.Immediate cause of death Cerebral Hemorrhage
Arteriosclerosis Right side
Due to Arteriosclerosis 3 days
18 monthsDue to Hypertensive Cardio -
Renal disease 18 monthsOther conditions Stroke

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. _____

Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

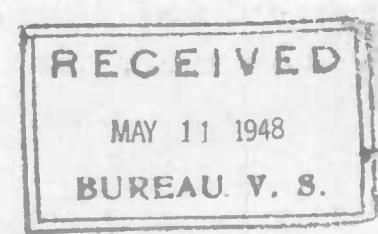
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE George J. Kneis, Jr. M. or other _____Address Elk Mills, Md. Date signed 5 May 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04995

CERTIFICATE OF DEATH

1248
BC

Reg. Dist. No. 96

1. PLACE OF DEATH:

County CecilCity or town Perry Point, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

VA Hospital, Perry Point, Md.How long in hospital or institution? Same as above

3. (a) FULL NAME

COLLINS, James

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	Divorced

6. (b) Name of husband or wife —7. Birth date of deceased (mo., day, yr.) July 8, 18946. (c) If alive, give age — years

8. AGE: Years	Months	Days	If less than one day
53	10	15	hrs. <u>—</u> min. <u>—</u>

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Unknown

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Hospital RecordsAddress —17. Removal Removal Date thereof May 24, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oaklawn CemeteryLocation Baltimore, Md.18. Funeral director PENNINGTON & SON
Address Bavre de Grace, Md.19. May 24 1948 Done E. Daugherty
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore (If outside city or town limits, write RURAL and give nearest town)Street No. 743 S. Luzerne Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war WW-I

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1948, 21 2:00 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 1948, to May 23, 1948,and that I last saw him alive on May 23, 1948.Immediate cause of death Uremic poisoning DURATION 14.16 daysDue to Cardiovascular renal disease UNKNOWNDue to —Other conditions 1. Arteriosclerosis, generalized and coronary; 2. Cirrhosis of the liver UNKNOWN
(Indicate pregnancy within 3 months of death)Major findings of operations — Date of op. —Autopsy results — PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State) —Injured at home, farm, industry, public place (where?) — Injured at work? —Means of injury — Injured at work? —23. SIGNATURE J. Z. Trellinger M.D. or other

A.E. TROLLINGER, M.D., Chief, Professional

Address VA Hospital, Perry Point, Md. Date signed 5-21-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04996

94

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... CecilCity or town..... Charlestown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Edna ACooper

3. (b) Social Security Number

none4. Sex..... Female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... Married6. (b) Name of husband or wife..... Cecil C Cooper7. Birth date of deceased (mo., day, yr.)..... Sept 2 1800 6. (c) If alive, give age..... 48 years8. AGE: Years..... 47 Months..... 8 Days..... 1 If less than one day.....9. Birthplace..... Principio Furnace Cecil Co Md (Town, county, and state)10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Newton W Anderson13. Birthplace..... Principio Furnace Md14. Maiden name..... Ella Blakeman

15. Birthplace.....

16. Informant..... Cecil C CooperAddress..... Charlestown Md17. Burial, cremation, or removal?..... Burial Date thereof..... 5-5-48 (month) (day) (year)Cemetery or crematory..... Principio MethodistLocation..... Principio Furnace18. Funeral director..... Jasper A GreenAddress..... North East Md19. 5-5-48 19..... 48 M. D. 000000(Date rec'd by registrar) May 18 Deputy B. Martin Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MdCounty..... CecilCity or town..... Charlestown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 3rd 19..... 48 a. 2:05 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1st 19..... 48 to May 3 19..... 48and that I last saw her alive on May 1 19..... 48

Immediate cause of death.....

Metastatic Carcinoma of LungDue to..... Carcinoma of Breast DURATION..... 18 mo

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

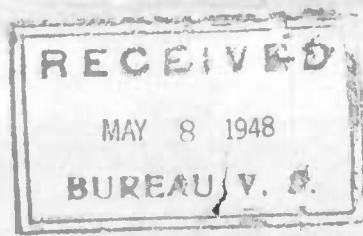
Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE..... J. F. MagruderM. D. 000000Address..... Perryville Md Date signed..... 5/3/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04997

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

9-45-15

VS A15

1. PLACE OF DEATH:

County

Cecil

City or town

North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

About 50 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Theodore W. Culley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White Married

6. (b) Name of husband or wife

Susie C Culley

7. Birth date of deceased (mo. day, yr.)

Sept 22, 1870

6. (c) If alive, give age 74 years

8. AGE:

Years

Months

Days

If less than one day

77 7 20 hrs. min.

9. Birthplace

Lancaster Co Penna

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Robert A Culley

MOTHER FATHER

12. Name

Susie C Culley

Penns

13. Birthplace

Penns

14. Maiden name

Caroline Poole

15. Birthplace

Penns

16. Informant

Mrs Susie Culley

Address

North East, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 14, 1948

(month) (day) (year)

Cemetery or crematory

Methodist Cem

Location

Blessing Grove, Penns

18. Funeral director

Joseph R. Grant

Address

North East, Md

19. 5-14

(Date rec'd by registrar)

1948

Myrtle B. Martin

Deep

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland

County

Cecil

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

222-10-8016

MEDICAL CERTIFICATION

2D. DATE OF DEATH

11 May 1948 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 1948 to 10 May 1948

and that I last saw him alive on 10 May 1948

Immediate cause of death

Cerebral Hemorrhage

Due to Hypertensive Cardiovascular Disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

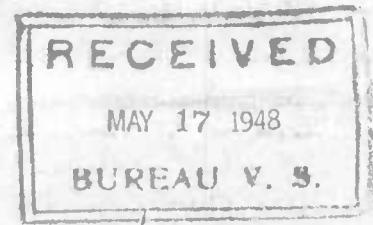
Injured at work?

23. SIGNATURE

Klaus H. Hartman M.D.

M. D. or other

Address North East, Md Date signed 14 May 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04998

CERTIFICATE OF DEATH

928
Reg. Dist. No. 90

1. PLACE OF DEATH:

County

Cecilton

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

54

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lewin J. Davis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age

years

June 11 1908

8. AGE:

Years

Months

Days

11 less than one day

39 10 20 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date recd. by registrar

1948

May 3 1948

Mrs. Harriet W. Cheyney

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

Md. Cecil

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

2001

MEDICAL CERTIFICATION

2D. DATE OF DEATH

April 1st 1948 at 3:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 4 1948 to May 1st 1948
and that I last saw h. in alive on April 30 1948

Immediate cause of death

1. myocardial failure

Due to

2. mitral insufficiency

Due to

3. arteriole hard disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Allen R Cheyney M.D.

M. D. Father

Address

Mudletown Del Date signed

RECEIVED
MAY 5 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04903

CERTIFICATE OF DEATH

112
Reg. Distr. No. 96

1. PLACE OF DEATH:

County..... CECIL

City or town..... PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 mos. 24 das.

Hospital, institution, or street address where death occurred:

VAH, Perry Point, Md.

How long in hospital or institution?..... Same as above

3. (a) FULL NAME

Charles W. Dick

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

Male

White

Divorced

6.(b) Name of husband or wife..... --

7. Birth date of deceased (mo. day, yr.)..... November 17, 1911

6.(c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day.....

36

5

17

.hrs.

min.

9. Birthplace..... Westernport, Maryland

(Town, county, and state)

10. Usual occupation..... Truck Driver

11. Industry or business.....

12. Name..... John Randolph Dick

13. Birthplace..... Harton, Maryland

14. Maiden name..... Margaret Laretta Morgan

15. Birthplace..... Westernport, Maryland

16. Informant..... Hospital Records

Address..... VAH, Perry Point, Maryland

17. Removal..... Date thereof..... May 5, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Unknown

Location..... Cresaptown, Maryland

18. Funeral director..... FUNERAL HOME

Address..... Green & Smallwood Street

Address..... Cumberland, Maryland

19. Date record by registrar..... May 5, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Allegany

City or town..... Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 4th 1948 at 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10 1948 to May 4th 1948

and that I last saw him alive on May 4th 1948

Immediate cause of death.....

DURATION

XXXX Cardiac Failure

2 mos.

Due to..... Bronchial Asthma

3 mos.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results..... No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

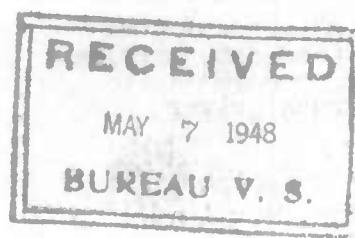
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... H. NAGLER, M.D., Act. Chf., Prof. Services

M. D. or other

Address..... VAH, Perry Point, Md. Date signed..... 5/5/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04910

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County

City or town

Ellicott

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

30 minutes

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

30 minutes

3. (a) FULL NAME

William D Fowler

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Mr.

Single married

6. (b) Name of husband or wife

Kathryn Fowler

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

January 21, 1904

8. AGE:

Years

Months

Days

If less than one day

44

3

12

hrs. min.

9. Birthplace

Chester town, Md

(Town, county, and state)

10. Usual occupation

Crown City Power Co

11. Industry or business

MOTHER FATHER

Harry Fowler

13. Birthplace

Chester town, Md

14. Maiden name

Agnes Newcomb

15. Birthplace

Chester town, Md

16. Informant

Mrs. Wm D. Fowler

Address

211 E Main St Elkton, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Elkton, Md

Cemetery or crematory

Elkton, Md

Location

Elkton, Md

18. Funeral director

Hawkins

Address

Elkton, Md

19. Date rec'd by registrar

May 5 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md. Cecil

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 211 East Main

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

216-05-6089

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1948 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to... 19...

and that I last saw h... alive on...

Immediate cause of death

Cerebral
Temporary
disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

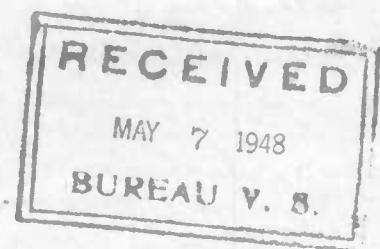
Means of injury

Injured at work

R. D. Dodson M.D. Medical Examiner
for Cecil County

M. D. or other

Address 103-48 Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d 0491-92
Reg. Dist. No.

1. PLACE OF DEATH: *Cecil*
County.....
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *15 yrs*Hospital, institution, or street address where death occurred: *Union Hospital*How long in hospital or institution? *2 wks.*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... *Md.* County..... *Cecil*City or town..... *Rural near Elkton*

(If outside city or town limits, write RURAL and give nearest town)

Street No..... *R.D. 2*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Thomas Freeman

3.(b) Social Security Number

4. Sex *M.* 5. Color or race *wh.* 6.(a) Single, married, widowed, or divorced *Widowed*8.(b) Name of husband or wife *Lothi M. Donald Freeman*7. Birth date of deceased (mo., day, yr.) *In Utk.* 8.(c) If alive, give age *1868* years8. AGE: Years *79* Months Days If less than one day hrs. min. 9. Birthplace *Elkton Md.*
(Town, county, and state)10. Usual occupation *Laborer*11. Industry or business *Wealey Freeman*12. Name *Freeman*
13. Birthplace *Elkton Md.*14. Maiden name *Mary J. Freeman*
15. Birthplace *Elkton Md.*16. Informant *Anthony Pothwell*
Address *Elkton R.D. 2 Md.*17. Burial *May 7/48*
(Burial, cremation, or removal. Which?) Date thereof *May 7/48* (month) (day) (year)Cemetery or crematory *Silverbrook*
Location *Wilmington Del.*18. Funeral director *Herbert B. Babb*
Address *Elkton Md.*19. May 5 1948
(Date rec'd by registrar) *J R Frazer*
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 3 1948* at *7:00* M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

March 1 1948 to *May 3 1948*and that I last saw him alive on *May 3 1948*Immediate cause of death *Coronary Thrombosis*DURATION *2 days*

Due to.....

Due to.....

Other conditions *Chronic Endocarditis**Acute myocarditis*

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

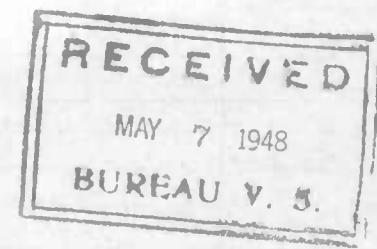
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Herbert Babb M.D.* M. D. or other *Elkton Md.*Address *Elkton Md.* Date signed *May 5 1948*



1 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04912
131a

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... Cecil

City or town..... Perry Point, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 Month & 18 Days

Hospital, Institution, or street address where death occurred:

VA Hospital, Perry Point, Md.

How long in hospital or institution?..... 1 Month & 18 Days

3. (a) FULL NAME

Graham, Delbert D.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife

Florence F. Graham, Wife

7. Birth date of deceased (mo., day, yr.)

June 20, 1894

6.(c) If alive, give age..... 51 years

8. AGE:

Years

Months

Days

If less than one day

54

10

21

hrs.

min.

9. Birthplace..... Tacoma, Washington

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

12. Name..... Jacob W. Graham

13. Birthplace..... Ireland

14. Maiden name..... Annie K. Douglas

15. Birthplace..... Ireland

16. Informant..... Hospital Records

Address VAH, Perry Point, Maryland

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof..... 5-31-48

(month) (day) (year)

Cemetery or crematory..... Arlington National Cemetery

Arlington, Virginia

Location.....

18. Funeral director.....

J. Arthur Walters

Address 254 Carroll N.W., Takoma Park, Md.

19. 5-31-48

19. 48

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince George

City or town..... Takoma Park (If outside city or town limits, write RURAL and give nearest town)

Street No..... 126 New York Ave., (If rural, give LOCATION)

2.(a) If veteran, name war..... WW 1

3. (b) Social Security Number

577-18-0334

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 31,

19 48 at 3:05 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 13, 1948 to May 31, 1948

and that I last saw h. im. alive on May 31, 1948

Immediate cause of death.....

Hemorrhage, ventricular, right

DURATION

9 hrs.

Due to..... Hypertensive cardio-vascular renal disease

3 yrs.?

Due to.....

Other conditions..... Arteriosclerosis generalized, 3 yrs. bronchial pneumonia.

(Include pregnancy within 3 months of death)

10 Hrs.

Major findings of operations.....

Date of op.

Autopsy results..... Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

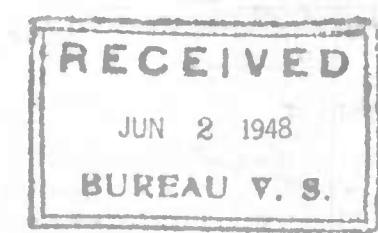
Means of injury.....

Injured at work?

23. SIGNATURE.....

W. OPPLER, M.D., M.D. or other

Acting Chief, Professional Services, Address..... VAH, Perry Point, Md. Date signed..... 5-31-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04913

1246

96

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... CecilCity or town..... Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Life

How long in above place of death?

Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alexander Wayman Griffin

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Colored

Married

6.(b) Name of husband or wife.....

Eva L. Griffin

7. Birth date of deceased (mo., day, yr.)

Nov. 1, 1874

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

73

6

4

.hrs.

min.

9. Birthplace.....

Port Deposit, Cecil Co., Md.

(Town, county, and state)

10. Usual occupation.....

Blaster

11. Industry or business.....

Stone Quarry

MOTHER FATHER

William Griffin

13. Birthplace.....

Harford Co., Md.

14. Maiden name.....

Sarah J. Dunmore

15. Birthplace.....

Cecil Co., Md.

16. Informant.....

Oscar W. Griffin

Address

Port Deposit, Md.

17. Burial.....

BurialDate thereof..... May, 8, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Jones Memorial Cem.

Location.....

Port Deposit, Md. Rural

18. Funeral director.....

Lee A. Patterson & Son

Address

Perryville, Md.19. May 8..... 48..... June E. Daugherty

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... CecilCity or town..... Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

215-10-4566

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 5, 48

19

3:03

A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 20..... 48 to May 5..... 48

19. to 19.

and that I last saw h. alive on May 4..... 48.

19. to 19.

Immediate cause of death.....

Spasmodic of LiverSclerosis?

DURATION

6 mos.

Due to.....

Due to.....

Other conditions..... Chronic nephritis - 7 yrs

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'l'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

B. H. Johnson M.D.

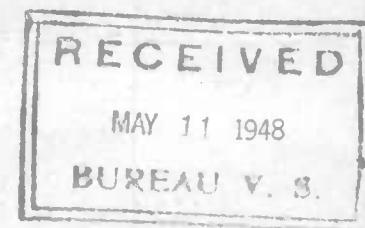
M. D. or other

Address.....

Port Deposit

Date signed.....

5/6/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04914

1310
Reg. Dist. No. 95

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Cecil

City or town

North East. Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ida Josephine Haley.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

John Thomas Haley

7. Birth date of deceased (mo., day, yr.)

May 23 1873

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

75

4

hrs.

min.

9. Birthplace

Kent Co. Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

James Sher

13. Birthplace

Kent Co. Md.

14. Maiden name

Martha Shelton

15. Birthplace

Md.

16. Informant

Mrs. Martha Haniffee

Address

Earlville. Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 31 1948

(month) (day) (year)

Cemetery or crematory

St. Dennis

Location

Galena Md.

18. Funeral director

E. Tyson

Address

Rising Sun. Md.

19. (Date rec'd by registrar)

May 30 1948

19

Permit issued

1-31-48

(Date rec'd by registrar)

19

Permit issued

1-31-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Cecil

City or town

Cecilton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 27

48, at 11:17 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 21 1948 to May 27 1948

and that I last saw her alive on May 25 1948

Immediate cause of death

Chronic Intestinal

Due to

Inflammation

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

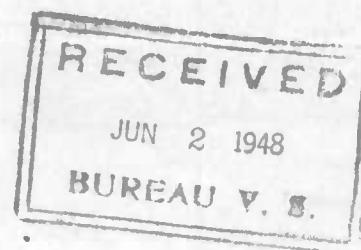
Injured at work?

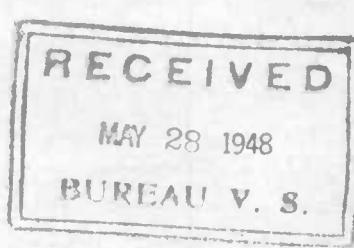
23. SIGNATURE

Re Dodsorah

Rising Sun Md. Date signed 6/28/48

Address





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04916

CERTIFICATE OF DEATH

48a
Reg. Dist. No.

92

1. PLACE OF DEATH:

County.....

Belleville
Electon

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

9 days

Hospital, Institution, or street address where death occurred:

Union Hosp.

How long in hospital or institution?.....

9 days

3. (a) FULL NAME

May Lowman Hayes

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife

Albert E. Hayes

7. Birth date of deceased (mo., day, year)

May 1, 1913

6. (c) If alive, give age..... years

36

8. AGE: Years

Months

Days

It less than one day

35 11/5

hrs.

min.

9. Birthplace.....

Denton - Md

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

Albert Lowman

12. Name.....

Maryland

13. Birthplace.....

Talie T. Tarbutton

14. Maiden name.....

Maryland

15. Birthplace.....

The deceased

16. Informant.....

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... May 5, 1948
(month) (day) (year)

Cemetery or crematory..... Odd Fellows Cemetery

Location..... Smyrna, Delaware

18. Funeral director..... Wells Staries

Address..... Smyrna, Delaware

19. Date rec'd by registrar..... May 3, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil

City or town..... Warwick - Md (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 2 - 1948 at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 23 1948 to May 2 1948 and that I last saw her alive on May 2 1948

Immediate cause of death.....

Cancer of cervix - Bowels unknown + bladder

Due to..... uterus - Having been removed

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

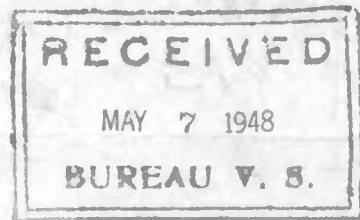
Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Elton - Md

Date signed..... May 14, 1948



1 MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY. WITH UNFADING INK. Supply every item of information carefully. The correct appa

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04917

CERTIFICATE OF DEATH

468
Reg. Dist. No. 91

1. PLACE OF DEATH:

County: Essex
City or town: Chesapeake
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 52 yearsHospital, institution, or street address where death occurred: at home

How long in hospital or institution?

3. (a) FULL NAME

Harry Hyland Howard4. Sex: Male 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Widowed6. (b) Name of husband or wife: Ellis W. Howard7. Birth date of deceased (mo., day, yr.): February 11- 1866 6. (c) If alive, give age: 52 years8. AGE:

Years: <u>82</u>	Months: <u>3</u>	Days: <u>0</u>	Less than one day: <u>0</u>
hrs. <u>0</u>	min. <u>0</u>		

9. Birthplace: Cecil Co. Md. (Town, county, and state)10. Usual occupation: Retired Farmer11. Industry or business: Farming12. Name: Ellis W. Howard Father13. Birthplace: Maryland14. Maiden name: Mary E. Bonham15. Birthplace: Cecil Co. Maryland16. Informant: Elton J. DavisAddress: Chesapeake, Md.17. Burial: Burial Date thereof: May 13-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory: Bethel May 13 1948Location: Chesapeake City18. Funeral director: People's R. GrantAddress: North East, Md.19. (Date read by registrar) May 14, 1948 Sam. Rapp & SonsRegistrar: Sam. Rapp & SonsAddress: Chesapeake, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: EssexCity or town: Chesapeake (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war: _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 19, 47 to May 11, 1948and that I last saw her alive on May 10, 1948Immediate cause of death: Carcinoma of stomachDURATION: 2 yearsDue to: 7

Due to: _____

Other conditions: Stomach tumor

(Include pregnancy within 8 months of death)

Major findings or operations: _____

Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: _____ Injured at work? _____

23. SIGNATURE: Henry Davis, M.D. M. D. or other: _____Address: Chesapeake, Md. Date signed: July 14, 1948

RECEIVED

MAY 14 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04918

CERTIFICATE OF DEATH

131a
Reg. Date. No. 94

1. PLACE OF DEATH:

County CecilCity or town North East, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Katherine S. Letts

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

Charles H. Letts

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 23, 1874

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

North East Rural Cecil Co. Md

(Town, county, and state)

10. Usual occupation

Business Mgr 2 yrs Retired

11. Industry or business

Telephone Co

MOTHER FATHER

12. Name

Charlotte Garrett

13. Birthplace

Phila Penna

14. Maiden name

Sydica A McCormick

15. Birthplace

Phila Penna

16. Informant

Garrett Letts

Address

North East,

17. Burial

Date thereof June 3, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Methodist

Location

North East Maryland

18. Funeral director

Joseph R. Grant

Address

North East, Md

19. Date rec'd by registrar

June 3, 1948

Sarah E. Rothermel

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

City or town North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

220-05-0215

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 -

1948, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 1948, to May 31 - 1948and that I last saw her alive on May 30, 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 daysDue to Chronic Malaria
neuritis.

10 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

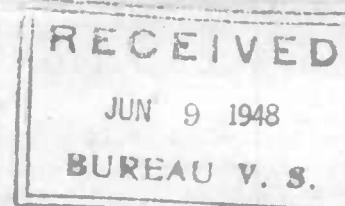
23. SIGNATURE

H. S. Campbell, M.D.

M. D. or other

Address North East, Md Date signed June 1/48

8-6-46
874-8-3
1948-4-31



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1248 04919

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County Cecil
City or town Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs. 7 months 12 days
Hospital, institution, or street address where death occurred:
Veterans Administration Hospital,
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5019 Eastern Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3. (a) FULL NAME

NEGREA, Jacob

4. Sex <u>male</u>	5. Color or race <u>white</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
--------------------	-------------------------------	---

6.(b) Name of husband or wife --7. Birth date of deceased (mo., day, yr.) Oct. 23, 1894

8. AGE: Years <u>53</u>	Months <u>6</u>	Days <u>22</u>	If less than one day hrs. <u>.....</u> min. <u>.....</u>
-------------------------	-----------------	----------------	---

9. Birthplace Rumania
(Town, county, and state)10. Usual occupation None11. Industry or business --

12. Name <u>Unknown</u>
13. Birthplace <u>Unknown</u>

14. Maiden name <u>Unknown</u>
15. Birthplace <u>Unknown</u>

16. Informant Hospital RecordsAddress VAH, Perry Point, Md.17. Removal Date thereof May 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore Nat'l Cem.Location Baltimore, Md.18. Funeral director JOHN G. DONNELLY
Address 418 Eastern Ave., Essex, Md.19. Date rec'd by registrar May 17, 1948 Irene E. Daugherty
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1948 at 11:10 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 3, 1947 to May 15, 1948, and that I last saw him alive on May 15, 1948.Immediate cause of death Cirrhosis, portal, with ascites DURATION UnknownDue to --Due to --Other conditions --

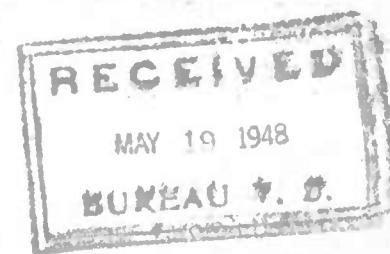
(Include pregnancy within 3 months of death)

Major findings or operations Peritoneoscopy and biopsy of liver confirmed above Date of op. 1-14-48Autopsy results --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --Where did injury occur? -- (City or town) -- (County) -- (State) --Injured at home, farm, industry, public place (where?) --Means of injury -- Injured at work? --3. SIGNATURE A. E. TROLLINGER, M.D. Chief Professional otherAddress VAH, Perry Point, Md. Date signed May 17, 1948



PLEASE WRITE PLAINLY,
WITH UNFADING INK. Supply every item of information carefully.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04920

CERTIFICATE OF DEATH

107
Reg. Diat. No.

96

1. PLACE OF DEATH:

County CecilCity or town Perry Point, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 yrs. 10 mos. 14 days

Hospital, Institution, or street address where death occurred:

VA Hospital, Perry Point, Md.How long in hospital or institution? Unknown

3. (a) FULL NAME

O'BRIEN, Florence Sylvester

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male	white	Single
------	-------	--------

6. (b) Name of husband or wife: 6. (c) If alive, give age years7. Birth date of deceased (mo. day. yr.) Apr. 20, 18948. AGE: Years 54 Months 0 Days 22 If less than one day hrs. min.9. Birthplace LeSuercenter, Minnesota
(Town, county, and state)10. Usual occupation Unknown

11. Industry or business

12. Name Unknown - deceased13. Birthplace Unknown14. Maiden name Unknown - deceased15. Birthplace Unknown16. Informant Hospital Records

Address

17. Removal Date thereof May 13, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director LEONARD J. RUCK
Address 5305 Harford Road, Baltimore 14, Md.19. May 13, 1948 Irene E. Dugay
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County City or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 36 T. Street, N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war WW-I

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1948 at 9:25 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28, 1933 to May 12, 1948and that I last saw him alive on May 12, 1948Immediate cause of death Bronchopneumonia, rightDURATION 4 daysDue to Atelectasis, left, massive DURATION 5-6 daysDue to DURATION Other conditions Schizophrenia DURATION 30 yrs.

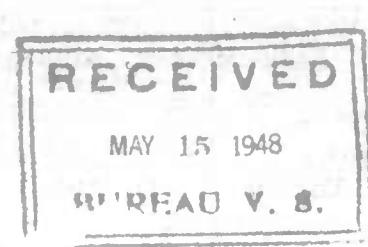
(Include pregnancy within 3 months of death)

Major findings of operations Leukotomy Date of op. May 6, 1948Leukotomy None - Normal brain Date of op. May 6, 1948Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE R. HAGLER, M.D., Actg. Chief, Professional
VAH, Perry Point, Md. Date signed May 13, 1948Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. True correctness is especially important. Physicians: please rewrite the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04921

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:

County Cecil
City or town North East
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days
Hospital, institution, or street address where death occurred: Cecil ave

How long in hospital or institution?

3. (a) FULL NAME

Lida (Virginia) U KO wens

3. (b) Social Security Number

none

4. Sex <u>Female</u>	5. Color or race <u>W.</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>	
		<u>Yes. W. (Dwens)</u>	
7. Birth date of deceased (mo., day, yr.) <u>Feb 6 1863</u>	6. (c) If alive, give age years		
8. AGE: Years <u>85</u>	Months <u>2</u>	Days <u>26</u>	If less than one day <u>7 hrs. 45 min.</u>

9. Birthplace
Philadelphia
(Town, county, and state)

10. Usual occupation
Housewife

11. Industry or business
Henry Eppelsheimer

12. Name
Henry Eppelsheimer

13. Birthplace
Philadelphia

14. Maiden name
Caroline Martin

15. Birthplace
Philadelphia

16. Informant
Charles Hamilton Martin

Address
Cecil ave North East Md

17. (Burial, cremation, or removal. Which?)
Burial Date thereof 5-6-48
(month) (day) (year)

Cemetery or crematory
North East Cem

Location
North East

18. Funeral director
Joseph R. Shantz

Address
North East Md

19. 5-6 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil
City or town North East
(If outside city or town limits, write RURAL and give nearest town)

Street No. Cecil ave
(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 May 1948 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1948 to May 1948
and that I last saw h.c.t. alive on 3 May 1948

Immediate cause of death

Pulmonary Edema DURATION 48 hours

Due to Hypertensive Cardiovascular Disease 5 years (?)

Due to...

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

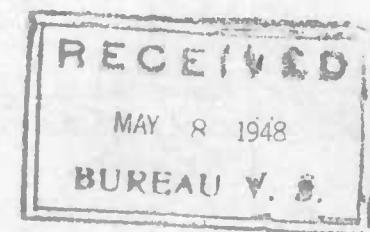
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Klaus H Huebner M.D. M. D. or other
Address North East Md Date signed 5 May 48

True correct age



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04922

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County

Cecilville

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Laura E. Pippin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day. yr.)

6. (c) If alive, give age

years

May 31 1869

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Md.

10. Usual occupation

Housework

11. Industry or business

MOTHER FATHER

12. Name

James Bradley

13. Birthplace

Md.

14. Maiden name

Susan Bunting

15. Birthplace

Md.

16. Informant

Mrs. Effie Pippin

Address

Henderson

Cecilville Md.

17. Burial

Date thereof

(month) (day) (year)

May 4 1948

Cemetery or crematory

John Brown

Cecilville Md.

Location

Edward Eller

Mallington

18. Funeral director

Walter H. Lin

Address

19. Date rec'd by registrar

May 4 1948

Mrs. Helen W. Cheyney

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. Cecil

City or town

Cecilville

Street No.

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1948 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from

June 19, 1948, to May 1, 1948

and that I last saw her alive on May 1, 1948

Immediate cause of death

Hypertension
Cardiovascular disease

DURATION

5 years

Due to

Acute dilatation of heart shown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

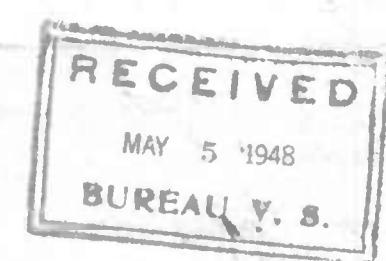
Injured at work?

23. SIGNATURE

Walter H. Lin

M. D. or other

Address Middleton Rd. Date signed 7/3/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

04923

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County...

Cecil
Ellston Rural

City or town...

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Diseasing

Hospital, institution, or street address where death occurred:

RD 3

How long in hospital or institution?

3. (a) FULL NAME

4. Sex:

5. Color or race:

6. (a) Single, married, widowed, or divorced

M. White Married
Edna D. Plank

6. (b) Name of husband or wife...

7. Birth date of
deceased (mo., day, yr.)

6. (c) If alive, give age... 60 years

8. AGE:

Years 67 Months 11 Days
It less than one day
hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation.

Pennsylvania
Carpenter.

11. Industry or business

James Plank

12. Name

Penn.

13. Birthplace

Elizabeth Wager

14. Maiden name

Penn.

15. Birthplace

Penn.

16. Informant

Mrs. Edna D. Plank

Address

Ellston RD Md.

17. Burial

Date thereof May 13/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Greenbush Memorial Park

Location

Dupont Blvd. New Orleans, Del.

18. Funeral director

H. Pippin

Address

Ellston, Md.

19. Date rec'd by registrar

May 13 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State...

Md.

County...

Cecil

City or town...

Ellston Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No...

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 10 1948 at 1300

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19....., 10..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death...

Fracture of
anterior fossa
base of brain

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 6/10-48

Where did injury occur Ellston, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

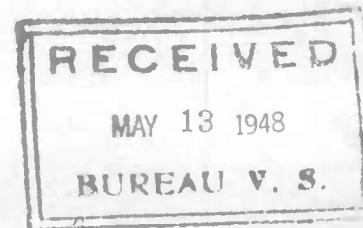
Means of injury Fall from Roof Farm Injured at work? Yes

23. SIGNATURE.....

Lee Dodson, M.D. Medical Examiner for Cecil County

M. D. or other Date signed 5/12/48

RECEIVED
MAY 15 1948
BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

136
04925

CERTIFICATE OF DEATH

96

Reg. Dist. No.

1. PLACE OF DEATH:

County..... **Cecil**City or town..... **Perry Point**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **15 yrs. 10 mos. 15 days**

Hospital, institution, or street address where death occurred:

VA Hospital, Perry Point, Md.

How long in hospital or institution?..... **Same as above**

3. (a) FULL NAME

ROHE, Emerson S.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

Single

6.(b) Name of husband or wife.....

--

7. Birth date of deceased (mo., day, yr.)

Feb. 9, 1900

6.(c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

48

2

23

hrs.

min.

9. Birthplace.....

Barnum, W. Va.

(Town, county, and state).

10. Usual occupation.....

Laborer

11. Industry or business

12. Name..... **Frank Rohe - deceased**

13. Birthplace

West Virginia

14. Maiden name.....

Elanor Henline - deceased

15. Birthplace

West Virginia16. Informant..... **Hospital Records**

Address

VA Hospital, Perry Point, Md.

17. Removal.....

Date thereof..... **May 3, 1948**

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or casket/box.....

Unknown

Location.....

Keyser, West Virginia

18. Funeral director.....

PENNINGTON & SON

Address

Havre de Grace, Maryland19. **May 3**

19. 48

June 8

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **West Virginia** County..... **Mineral**City or town..... **Keyser**

(If outside city or town limits, write RURAL and give nearest town)

Street No..... **57 Carroll Avenue**

(If rural, give LOCATION)

WW-I

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **May 2, 1948** at **1:00 AM**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **June 17, 1948** to **May 2, 1948**and that I last saw h. **1m** alive on **May 2, 1948**Immediate cause of death..... **Mesenteric thrombosis**

DURATION

approx.**12 hrs.**Due to..... **Arterosclerosis, generalized****Unknown**

Due to.....

Other conditions..... **Tuberculosis, pulmonary, chronic, active, far advanced**

(Include pregnancy within 3 months of death)

Unknown

Major findings of operations..... --

Date of op.

Autopsy results..... --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... --

Date of

Where did injury occur?..... --

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)..... --

Means of injury..... **O**

Injured at work?

23. SIGNATURE

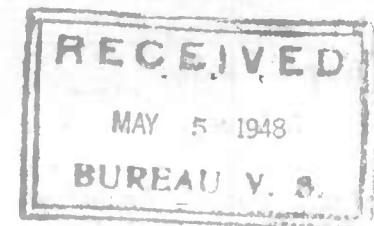
H. NAGLER, M.D. M.A.C.T. Chief, D. or other**Professional Services**Address..... **VAH, Perry Point, Md.**Date signed..... **May 3, 1948**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04926

96

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... **Cecil**
 City or town..... **Perry Point, Maryland**
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **2 months 18 days**Hospital, Institution, or street address where death occurred:
VA Hospital, Perry Point, MarylandHow long in hospital or institution?..... **2 months 18 days**

3. (a) FULL NAME

SOCKMAN, George F.

4. Sex

Male | 5. Color or race..... **White** | 6.(a) Single, married, widowed, or divorced..... **Married**

6.(b) Name of husband or wife..... **Elizabeth Sockman**

7. Birth date of deceased (mo., day, yr.)

January 29, 18976.(c) If alive, give age..... **55** years

8. AGE:

Years	Months	Days	If less than one day
51	4	0	hrs. min.

9. Birthplace..... **Martin's Ferry, Ohio**

(Town, county, and state)

10. Usual occupation.

Laborer11. Industry or business..... **Steel mills**12. Name..... **Frank Sockman - deceased**13. Birthplace..... **Martin's Ferry, Ohio**

14. Maiden name.....

Unknown - deceased

15. Birthplace.....

Unknown16. Informant..... **Hospital records**Address..... **VA Hospital, Perry Point, Md.**

17. Removal.....

Date thereof..... **6/2/48**
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... **Arlington National Cemetery**Location..... **Ft. Myer, Virginia****Pennington & Son**

18. Funeral director.....

Address..... **Havre de Grace, Md.**19. Date rec'd by registrar..... **June 2, 1948**

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **District Columbia** County.....City or town..... **Washington**

(If outside city or town limits, write RURAL and give nearest town)

Street No..... **330 Rhode Island Avenue, N.E.**

(If rural, give LOCATION)

2.(a) If veteran, name war..... **WW-I**

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **May 29, 1948**

19..... at 5:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... **March 11, 1948**, to **May 29, 1948**, and that I last saw him alive on **May 29, 1948**.Immediate cause of death..... **Thrombosis, Coronary, left**

DURATION

4-6 hrs.Due to..... **Coronary Arteriosclerosis****Unknown**

Due to.....

Pulmonary Edema, Massive, Bilateral. Generalized Arteriosclerosis (Include pregnancy within 8 months of death)

Unknown

Major findings of operation.....

Date of op.

Autopsy results..... **Same as above**

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

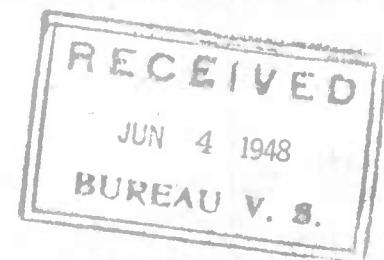
Injured at home, farm, industry, public place (where?)

Means of injury.....

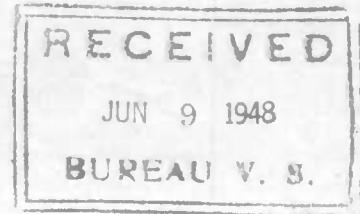
Injured at work?

23. SIGNATURE

W. O. SPOLER, M.D., Acting Chief
of Professional Services
VAH, Perry Point, Md.Date signed..... **1/2/48**



SLB 1
CL
84b/



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

04928

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County

Cecil

City or town

Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Emily
(Emma) Thomas.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Single.

6. (b) Name of husband or wife

7. Birth date of
deceased (mo. day, yr.)

Sept 5 1849

years

8. AGE:

Years

Months

Days

If less than one day

98

8

13

hrs.

min.

9. Birthplace

Elkton Cecil Co. Md

(Town, county, and state)

10. Usual occupation

Dress maker

11. Industry or business

12. Name

John E Thomas

13. Birthplace

Md

14. Maiden name

Matilda Jones

15. Birthplace

Md

16. Informant

Miss Flora Brown

Address

204 North East, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 21 - 1948
(month) (day) (year)

Cemetery or crematory

Presbyterian

Location

Elkton

Maryland

18. Funeral director

Joseph R. Clark

Address

North East, Md

19. Date rec'd by registrar

May 19 1948

(Date rec'd by registrar)

F. B. Fraser
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md

County

Cecil

City or town

Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

206 North Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

E.D.

20. DATE OF DEATH

May 18

1948 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 to May 18 1948

and that I last saw her alive on

May 17

1948

Immediate cause of death

Heart Failure.

DURATION

Due to Generalized Arthritis -
Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. W. Spencey

M. D. or other

Address

Elkton Md Date signed May 18 1948

LETTER TO THE UNITED STATES ATTORNEY

FOR THE DISTRICT OF COLUMBIA

LETTER TO THE ATTORNEY

LETTER TO THE ATTORNEY



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

04921
92

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Cecil

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 hour

Hospital, institution, or street address where death occurred:

Cecil Hospital Elkhorn

How long in hospital or institution?

1 hour

3. (a) FULL NAME

Edward Tobin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

White

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

June 3, 1922

8. AGE:

Years

Months

Days

If less than one day

25

hrs.

min.

9. Birthplace: Detroit, Mich.

(Town, county, and state)

10. Usual occupation:

Salesman

11. Industry or business

MOTHER FATHER

12. Name: Edward M. Tobin

MOTHER

13. Birthplace: Plymouth, Penna.

FATHER

14. Maiden name: Vera Jenner

MOTHER

15. Birthplace: Plymouth, Penna.

FATHER

16. Informant: Richard M. Tobin

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof: May 8, 1948

(month) (day) (year)

Cemetery or crematory

Location

District of Columbia

18. Funeral director

W. G. Chambers Co.

Address

1400 Chapin St. N.W.

19. Date rec'd by registrar

May 8, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

DC

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 452 N. St NW

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1948, at 41 86 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw him alive on _____
 Immediate cause of death: Fractured left lower leg. Fractured left side of pelvis due to such internal hemorrhage
 Due to numerous lacerations

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 07/6/48

Where did injury occur? near Elkhorn Cem. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route 40

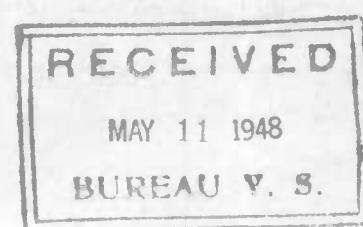
Means of injury: Automobile Injured at work? no

Medical Examiner
for Cecil County

M. D. or other

Date signed 5/8/48

Address: Youngsden Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04930

CERTIFICATE OF DEATH

107
Reg. Dist. No. 91

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Life time

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

Female

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

S-

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Nov. 6 - 1947

8. AGE: Years

Months

Days

If less than one day

0

6

3

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Port Deposit, Md

10. Usual occupation.....

v
v

11. Industry or business

Edwin Cornish -

FATHER

12. Name.....

Pgt Deposit, Md

13. Birthplace.....

Roberts Webster

MOTHER

14. Maiden name.....

Port Deposit, Md

15. Birthplace.....

Nellie Webster

16. Informant.....

Port Deposit, Md

Address.....

Hosanna

17. Burial (Burial, cremation, or removal. Which?)

Date thereof..... May 11, 1948
(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Port Deposit

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 9- 1948, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1, 1948, to May 9, 1948, and that I last saw her alive on May 9, 1948.

Immediate cause of death.....

Meningitis Pneumococci

Due to.....

Broncho-Pneumonia

Due to.....

Upper Respiratory Inf

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

M. D. or other

B. Johnson M.D.

Port Deposit, Md Date signed 5/10/48

Address.....

(Address)

